

CHAPTER 15 PERSONAL ASSISTANCE SERVICES

15-001 Scope and Authority

15-001.01 Scope: These regulations are established to ensure personal assistance services will support and augment independence, employment, empowerment, dignity, and human potential through provision of flexible, efficient, and needed services to eligible clients. Personal assistance services are intended to supplement the client's own personal abilities and resources.

15-001.02 Authority: Medicaid personal assistance services are defined in federal regulations at 42 CFR 440.167, and are an optional Medicaid benefit. The Nebraska Medical Assistance Program (NMAP), also known as Medicaid, offers personal assistance services as defined in 471 NAC 1-002, item 17. The Special Services for Children and Adults Division within the Nebraska Department of Health and Human Services has responsibility for administering personal assistance services within the Medicaid Program.

The Nebraska Legislature grants the authority to adopt rules and regulations for this service to the Director of the Department of Health and Human Services Finance and Support in Neb. Rev. Stat. § 68-1021.

15-002 Definitions of Terms: As used in this chapter, unless the context demands otherwise, the following definitions apply:

Activities of Daily Living (ADL) means those self-care activities which must be accomplished by an individual for continued well-being including mobility and transferring, dressing and grooming, bathing and personal hygiene, toileting/bladder care, and eating.

Adult Day Service means a person or any legal entity which provides care and an array of social, medical, or other support services for a period of less than 24 consecutive hours in a community-based program to person who require or request such services due to age or functional impairment.

Caretaker, as defined in Neb. Rev. Stat. § 71-1, 132.30 of the Nurse Practice Act, which explains health maintenance activities, means a person who (1) is directly and personally involved in providing care for a minor child or incompetent adult and (2) is the parent, foster parent, family member, friend, or legal guardian of such minor child or incompetent adult.

Central Office means the Special Services for Children and Adults Division within the Office of Aging and Disability Services in the Nebraska Department of Health and Human Services.

Client means the individual eligible for personal assistance services.

Competent adult, as defined in Neb. Rev. Stat. § 71-1, 132.30 of the Nurse Practice Act, which explains health maintenance activities, means someone who has the capability and capacity to make an informed decision.

Competitive integrated employment means working a minimum of 40 hours per month at minimum wage.

Department means the Nebraska Department of Health and Human Services.

Designee means any entity with whom the Nebraska Department of Health and Human Services Finance and Support has an interagency agreement or contract for administration or management of personal assistance services or for resource development.

Home environment means the client's primary residence which is not a setting that provides staff support or supervision, or any licensed health care facility, including assisted living facilities and other licensed residential service programs, and nursing facilities.

Licensed residential service program means an assisted living facility, center for the developmentally disabled, group home for the developmentally disabled, mental health center, substance abuse treatment center, and respite care service program. These programs are licensed by the Nebraska Department of Health and Human Services Regulation and Licensure.

Local office means the Nebraska Department of Health and Human Services office in or closest to the client's and/or provider's home community in Nebraska.

Personal assistance services means a task which provides the client's activities of daily living and other activities as listed in 471 NAC 15-003.01.

Provider or Personal assistance service provider means the individual who actually performs the personal assistance service(s) and meets the qualifications cited in 471 NAC 15-006.01.

Social Services Worker means the Nebraska Department of Health and Human Services employee at the local office who is responsible for working with clients to determine eligibility and authorize services.

15-003 Scope of Services

15-003.01 Covered Services: Personal assistance services include a defined range of human assistance, chosen and directed by the individual or designee or at the direction of a parent or guardian for a minor child or legally incompetent adult. Personal assistance services are provided to persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability.

Personal assistance services are based on individual needs and criteria that must be determined in a written assessment. Services authorized on a written service plan must relate directly to the needs identified in the assessment. (See 471 NAC 15-004.03C) Prior authorization must be obtained from Central Office for services authorized in excess of 40 hours per week. These services include:

1. Basic personal hygiene – providing or assisting with bathing (tub, bed bath, shower); shampoo, hair grooming; nail care; oral hygiene; shaving; and dressing;
2. Toileting/bowel and bladder care – assisting to and from bathroom, on and off toilet/commode, diapering, bedpan; external cleansing of perineal area; maintenance bowel care; and changing or emptying catheter bag;
3. Mobility, transfers, comfort – assisting with ambulation with and without aids; repositioning; encouraging active range-of-motion exercises; assisting with passive range-of-motion exercise; and assisting with transfers with or without mechanical devices;
4. Nutrition – preparing meals; planning and preparing special diets; assisting with fluid intake; and feeding; and
5. Medications – assisting with administration of medications; reminding appropriate persons when prescriptions need to be refilled.

15-003.01A Supportive Services: When any of the services listed in 471 NAC 15-003.01, items 1-5 are essential to enable the client to remain in the home and community, the following supportive services may also be provided:

1. Housekeeping tasks necessary to maintain the client in a healthy and safe environment (examples include changing the client's bed linens, laundering the client's bed linens and personal clothing, light cleaning in essential areas of the home used by the client; purchasing of food, and cleaning client's dishes. Note: These housekeeping activities may not be provided for the benefit of any other member of the household.); and
2. Accompanying and assisting the client with any mobility, transfers, or other needed services for physician office visits, or on other trips to obtain medical diagnosis or treatment when the client is unable to travel alone.

15-003.01B Specialized Procedures: Specialized procedures that would enable a person to live in his/her home and community may be performed by a personal assistance service provider at the direction of a competent client or of a caretaker for a minor child or incompetent adult client. Such procedures are considered 'health maintenance activities' under the Nebraska Nurse Practice Act (Neb. Rev. Stat. § 71-1, 132.30), and include, for example, insertion and care of catheters; irrigation of any body cavity; application of dressings involving prescription medication and sterile techniques; giving of injections into veins, muscles, or skin; filling insulin syringes; or administration of oxygen. The client's attending physician or registered nurse must determine that these procedures can safely be performed in the home and community by an approved personal assistance service provider

under the client's or caretaker's direction, the determination must be made for each specific client and his/her approved provider. Form MILTC-4D, "Physician/RN Statement for Health Maintenance Activities," attached to and incorporated in these regulations, provides a statement of determination for the safety of the health maintenance procedures to be performed by the personal assistance service provider(s) and the competency of the client or caretaker to determine that the provider is qualified to perform the procedure(s) needed.

15-003.01C Services Outside a Client's Home: Personal assistance services may be provided outside of a client's home, including at the client's worksite when the client is engaged in competitive integrated employment. Services provided may only include those authorized tasks that might otherwise be needed in the home and community (for example, assistance with toileting or eating a meal), and if at a worksite, may not be tasks which essentially perform the job the client was hired to do (for example, job coaching). Accompanying and assisting the client with needed services when the client has work-related travels is also allowable.

An individual residing in a licensed residential service program may only be eligible for personal assistance services under this regulation if it is needed to maintain competitive integrated employment or to attend an adult day care program.

15-003.02 Non-Allowable Services: Personal assistance services do not include the following:

1. Personal assistance services not documented in the service plan;
2. Personal assistance services provided by a legally responsible relative, defined as a spouse or parent of a child under 18 years of age;
3. Personal assistance services provided in excess of 40 hours per seven-day period, without prior authorization from Central Office;
4. Housekeeping services that are not an integral part of a covered personal assistance service (examples include cleaning areas of the home not used or occupied by the client, laundry other than that used by the client, preparation of meals for entire household, and shopping for groceries or household items other than those required for the health and maintenance of the client);
5. Services that are not listed as personal assistance services in 471 NAC 15-003.01;
6. Services provided without authorization;
7. A service provided and billed by a provider who is not approved to provide personal assistance services;
8. Companion services, which provide for a person to be present without specific tasks to be completed;
9. Services provided when a client is not Medicaid eligible; and
10. Services that are defined as personal assistance services in 471 NAC 15-003.01 but are being paid by the Department of Health and Human Services Finance and Support under some other arrangement or funding source.

15-004 Eligibility and Authorization

15-004.01 Eligibility Criteria: The Social Services Worker or designee must determine that a client meets eligibility criteria listed on Form MC-73, "Time Assessment and Service Plan," attached and incorporated, to proceed with the remainder of the authorization process. To be eligible for personal assistance services, a client must meet all of the following criteria:

1. Is a current Medicaid client;
2. Needs personal assistance services to live in the community;
3. Does not have needs that require more intensive services than those listed in 471 NAC 15-003.01 due to an acute health care level;
4. Is not receiving or eligible for personal assistance services or similar staff support based on their residence or place of employment. (An individual residing in a licensed residential service program may only be eligible for personal assistance services under this regulation if it is needed to maintain competitive integrated employment or to attend an adult day care center); and
5. Lives in a residence that is not a hospital, nursing facility, intermediate care facility, prison, or other institution.

15-004.01A Eligibility Criteria for Services in an Adult Day Service: The Social Services Worker or designee must determine that a client meets eligibility criteria listed on Form MS-82 "Adult Day Care Assessment/Authorization," in order to receive personal assistance services in an adult day service.

15-004.02 Assessment and Service Plan: The Social Services Worker or designee must complete Form MC-73 with the client.

15-004.02A Assessment Process: The Social Services Worker or designee must interview the client to determine eligibility for personal assistance services. Specifically, the Social Services Worker or designee will:

1. Determine if criteria in 471 NAC 15-004.01 is met. This criteria is listed on Form MC-73, and is assessed by asking the client to provide information;

2. Assess the client's specific needs for personal assistance service by asking the client to identify the tasks that s/he is unable to do that are essential to remain in the home and that must be performed by someone else;
3. Determine the services currently being provided and resources meeting any, some, or all of the client's needs by asking the client for this information. This may include determining if there is a need for language interpretation. Personal assistance services are not intended to replace the resources available to a client from their relatives, friends, and neighbors. Additionally, they should not be used to replace other governmental services; and
4. Record all of this information on Form MC-73.

15-004.02A1 Assessment and Authorization Process for Adult Day Services: The Social Services Worker or designee or the adult day service must interview the client to determine eligibility for personal assistance services in the adult day care setting. Form MS-82 must be utilized during this interview, following steps 1 through 4 in 15-004.02, rather than Form MC-73.

15-004.02B Service Plan Process: The Social Services Worker or designee must develop a service plan that identifies the services to be performed for the client. Specifically, the Social Services Worker or designee must complete the following steps, utilizing Form MC-73:

1. Utilizing the list of specific tasks identified in 471 NAC 15-004.02A, item 2, and together with the client, determine the time each task identified will reasonably require;
2. Determine the number of units to be authorized for personal assistance service based on the joint determination of needed tasks and time required;
3. Together with the client, discuss the client's preference for a personal assistance service provider. If the client has a preference of provider(s), the Social Services Worker or designee must include the name(s) on the service plan. It is helpful for the client to have arrangements for an alternative provider, for emergency purposes (see 471 NAC 15-004.03E2);
NOTE: A legally responsible relative (spouse or parent/stepparent of minor child) is not allowed to be a personal assistance provider.
4. Together with the client, review and sign Form MC-73; and
5. Give a copy of Form MC-73 to the client and approved provider, and place the original in the client's file.

The client and/or legal guardian must be an integral part of the development of the assessment and service plan by stating their service needs and preferences, and jointly determining the units of service needed.

15-004.02B1 Physician/RN Statement for Health Maintenance Activities: The Social Services Worker or designee must send Form MILTC-4D, "Physician/RN Statement for Health Maintenance Activities," to the client's physician or registered nurse to sign and return, if such specialized procedures as are described in 471 NAC 15-003.01B are needed. Specialized procedures may only be authorized for the client if the client's physician or registered nurse signs and returns the form to the Social Services Worker or designee.

15-004.02B2 Service Plan Process for Clients Utilizing Adult Day Care Centers: When personal assistance services will be provided by an adult day care center, the Social Services Worker or designee determines the number of day per week services will be provided and authorizes the service by:

1. Completing Form MS-82; and
2. Sending a copy of the form to the adult day care center.
NOTE: If the client is receiving both Nursing and Personal Assistance Services at the adult day care center, the Social Services Worker or designee must authorize both under "nursing services days (RN)" on Form MS-82.

15-004.02B3 Employer Appointment of Agent Form: At this time, before authorization of a personal assistance service provider, the Social Services Worker or designee must obtain the client's signature on IRS Form 2678, "Employer Appointment of Agent." This form is only required to be completed once, regardless of the number of approved providers that the client utilizes.

15-004.03 Authorization

15-004.03A Prior Authorization: Personal assistance services must be authorized before actual provision of the service, based on an assessment and service plan.

15-004.03B Limitation: Personal assistance services are limited to a maximum of 40 hours per seven-day period. Only the Social Services Worker or designee, not the approved service provider, may increase the maximum number of units for which the client is eligible per week, within the 40-hour per seven-day maximum. Any services provided in excess of 40 hours per seven-day period must receive prior authorization from Central Office.

15-004.03C Relationship to Service Plan: Personal assistance services authorized must relate directly to the tasks needed to be performed by someone else and that are essential to remain in the home, as listed on Form MC-73.

15-004.03D Authorization Process: The Social Services Worker or designee must prior authorize services, and may only do so if s/he has developed a service plan in collaboration with the client, and the document has been signed by the client and the worker.

The Social Services Worker or designee must complete Form MILTC-4B, "Notice and Authorization for Personal Assistance Services," and give a copy to both the client and personal assistance service provider. The Social Services Worker must list the following information on Form MILTC-4B:

1. Client's name and address;
2. Approved provider's name, contact information and provider number;
3. Authorized service tasks;
4. Authorization period (up to one year);
5. Authorized units; and
6. Social Services Worker or designee's name and phone number.

Before the authorization of an approved personal assistance provider, the Social Services Worker or designee must assure that the client has signed an IRS Form 2678, "Employer Appointment of Agent."

15-004.03D1 Authorization Period for Client Services:

1. The Social Services Worker or designee may not authorize services before the date that client eligibility for the service is determined.
2. The Social Services Worker or designee must authorize services based on the client's service needs for a period not to exceed a maximum of one year from the service authorization begin date.
3. To continue receiving services after the expiration of the authorization period, the Social Services Worker or designee must reauthorize services. (See 471 NAC 15-004.04)

15-004.03D2 Authorization Period of Providers: The Social Services Worker or designee may only authorize a provider until the end date of the client's existing authorization for services.

15-004.03D3 Authorization of Multiple Providers: The Social Services Worker or designee must, with the client, determine the maximum number of units each provider will be authorized to provide. It is the client's responsibility to determine the day-to-day schedule of each provider.

15-004.03E Emergency Authorization for Clients Already Receiving Personal Assistance Services: If a client's approved provider becomes unavailable with little or no notice, and the client is in need of the authorized service immediately, the Social Services Worker or designee may need to authorize an alternative provider without having completed the provider approval process described in 471 NAC 15-006.03.

15-004.03E1 Limitation: The Social Services Worker or designee may not authorize an alternative provider before the first date of the original provider's unavailability.

15-004.03E2 Client's Responsibilities: In order to receive emergency approval for an alternative provider, the client must:

1. Find a provider and inform him/her of the authorized services to be provided, as well as the need to go through the Department approval process in order to receive payment for services; and
2. Notify the Social Services Worker or designee of the situation and contact information for the alternative provider within one working day of finding the alternative provider.

15-004.03E3 Department Responsibilities: Once the Social Services Worker or designee is notified of the alternative provider, s/he must:

1. Immediately authorize the alternative provider to provide personal assistance services for the client, using the process described in 471 NAC 15-004.03D;
2. Send Form MILTC-4B to the alternative provider and the client; and
3. Notify the local office provider approval staff or their designee within three working days of the need to initiate the provider approval process.

15-004.03E4 Initiation of Alternative Provider Approval: The local office provider approval staff or designee must initiate the provider approval process described in 471 NAC 15-006.03D within three working days of notification by the Social Services Worker or designee.

15-004.03E5 Denying Approval of Alternative Provider: If the alternative provider cannot be approved due to inability to meet criteria listed in 471 NAC 15-006.01, s/he will only be paid for services provided up to and including the day that this determination is made. In this situation, the Social Services Worker or designee must notify the alternative provider and the client in writing and terminate the provider authorization within 10 working days of the determination.

15-004.04 Review of Service Plan and Re-Authorization: Personal assistance services must be re-authorized at the end of an authorization period, which is at least annually, based on continued eligibility and a review of the service plan. The Social Services Worker or designee must review the service plan together with the client a minimum of once every 12 months, or whenever the client's service needs change.

The Social Services Worker or designee must contact the client in writing at least 30 days before the end of the 12-month period to request a review of the service plan. If the client does not respond, his/her service authorization will expire.

If the client desires his/her service provider(s) to participate in the review, the client must inform the Social Services Worker or designee, who must then make arrangements for this to occur. At the review, if the client continues to meet eligibility requirements, the Social Services Worker or designee must:

1. Complete a new Form MC-73, or initial and date the existing Form MC-73 if no changes are needed;
2. Complete Form MILTC-4B; and
3. Give a copy of Forms MC-73 and MILTC-4B to the client and provider(s), and place the originals in the client's file.

15-004.04A Review and Reauthorization in an Adult Day Service: The Social Services Worker or designee or the adult day care center must review Form MS-82 with the client to determine the continued need for service. This re-assessment must be done a minimum of every 12 months or when ever the client's service needs change. Either a new Form MS-82 must be completed, or the existing Form MC-73 must be initialed and dated if no changes are needed.

15-005 Client Rights and Responsibilities

15-005.01 Client Rights: Clients who are found to be eligible for personal assistance services have the right to:

1. Identify their service needs;
2. Determine their preferred approved provider, which may include selecting from a Medicaid-approved list of providers;
3. Identify a possible provider who meets minimum qualifications as described in 471 NAC 15-006.01, but who is not yet approved to provide services;
4. Direct their personal assistance services;
5. Receive services according to the service plan, free from risk of harm or exploitation, including physical and verbal abuse, theft and misuse of household belongings, personal funds, prescriptions or other medical supplies; and
6. Evaluate their personal assistance service provider(s) in the authorized task(s).

If the client is not able to exercise these rights, a designated responsible party who is able to perform these functions for the client may do so.

15-005.02 Client Responsibilities: Clients receiving personal assistance services have the responsibilities to:

1. Disclose necessary medical information to the personal assistance service provider to allow for the safety of both the client and provider;
2. Notify the Social Services Worker or designee of any changes in their medical condition or service needs;
3. Schedule provider(s) within the parameters of the Authorization Notice;
4. Notify the Social Services Worker or designee if the provider is not performing the tasks for which s/he is authorized;
5. Notify the Social Services Worker or designee of any harm or exploitation by the provider, including physical and verbal abuse, theft and misuse of household belongings, personal funds, prescriptions or other medical supplies;
6. Approve all provider payments by signing Form MC-37, "Service Provider Time Sheet," if the information on the form is accurate;
7. Sign the IRS Form 2678, "Employer Appointment of Agent";
8. Be at home or other designated location when the provider arrives to carry out scheduled authorized tasks;
9. Ensure that the provider is free from risk of harm while performing the authorized tasks;
10. Follow the terms of the service plan and Form MILTC-4B, "Notice and Authorization for Personal Assistance Services," which specify the parameters of reimbursable personal assistance services and providers;
11. Formulate a back-up plan for provision of services in case of provider emergency; and
12. If a provider emergency arises, initiate the back-up plan for provision of services.

15-005.03 Client Notification: The Social Services Worker or designee must send written notice of denial, reduction, or termination of services to the client/guardian. Most often, the notice used is Form HHS-6 or a computer-generated notice. Notice to clients/guardians must contain:

1. A clear statement of the action to be taken;
2. A clear statement of the reason for the action;
3. A specific regulation citation which supports the action; and
4. A complete statement of the client/guardian's right to appeal.

Notice of reduction or termination of services must be mailed at least ten calendar days before the effective date of action. Exception: If the termination of personal assistance services is because of loss of Medicaid eligibility, the effective date of the termination must match the effective date of the termination of Medicaid eligibility.

15-005.03A Changes to Authorization: The Social Services Worker or designee must notify the client in writing of any change in the authorized service, including:

1. Change in service tasks to be provided;
2. Change in authorized units;
3. Change in approved provider; or
4. Change in authorization period.

The Social Services Worker or designee must send an updated Authorization Notice to the client within five working days of the change.

15-005.03B Denial/Termination Reasons: The Social Services Worker or designee must provide notice of denying or terminating eligibility for the following reasons:

1. The client has no personal assistance service need;
2. The client's needs are being met by another source;
3. The client/guardian has not supplied needed information to complete the eligibility process;
4. The client fails to meet the specified eligibility criteria in 471 NAC 15-004.01;
5. Specific component(s) of the service plan (e.g., services to be provided, number of units to be authorized) cannot be agreed upon by the Social Services Worker or designee and the client;
6. The client/guardian voluntarily withdraws;
7. The client moves out of Nebraska;
8. The client dies;
9. The Department loses contact with the client and his/her whereabouts are unknown;
10. The client has not made him/herself available to the provider(s) at scheduled times by being home or at other designated locations, three or more times in a 30-day period;
11. The client or household member has demonstrated violence toward the provider(s);
12. The client has provided an unsafe and dangerous environment in which the provider(s) has been expected to work; or
13. An authorization period is ending and the client/guardian has not acted upon a written notice of the need for re-authorization.

15-005.03C Advance Notice Not Required: The Social Services Worker or designee must provide a notice of action to close a case (Form HHS-6 or computer generated notice), but notice may be provided without the ten-day advance in the following situations:

1. The Social Services Worker or designee has factual information confirming the death of a client;
2. The Social Services Worker or designee receives a clear written statement signed by a client that he/she no longer wishes services;
3. The client has been admitted to a nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease;
4. The client's whereabouts are unknown; or
5. The Social Services worker or designee establishes the fact that the client has been accepted for Medicaid services by another state.

15-005.03D Provider Notice: When a client's personal assistance services are being changed in any way or terminated, the Social Services Worker or designee must provide written notice to the provider of the change in service provision or termination of payment for personal assistance services (Form MILTC-4C or computer-generated notice).

15-005.04 Client Appeals of Adverse Actions: Persons who request, apply for, or receive services may appeal any adverse action or inaction of the Department. These may include a potential client being denied personal assistance services, a client's services being reduced, or a client being determined ineligible for continued personal assistance services or other similar decisions. The Department of Health and Human Services must provide opportunities for fair hearings as defined in 42 CFR 431, Subpart E, to clients or their legal representatives who are denied personal assistance services (see 465 NAC 2-001.02 and 6-000).

15-006 Provider Requirements

15-006.01 Basic Provider Qualifications: To become an approved personal assistance provider, an applicant must:

1. Be age 19 or older;
2. Agree to all General Provider Standards listed on Form MILTC-9, "Service Provider Agreement," (see 471 NAC 15-006.01A);
3. Not be an employee of the Department or its designees if s/he is in a position to influence his/her own approval or utilization;
4. Not be a relative of the Department staff person or designee responsible for his/her approval as a personal assistance service provider. (NOTE: In situations where a Department staff person's or designee's relative is the only resource, staff must obtain approval from the HHS Service Area Long-Term Care Administrator);
5. Be capable of recognizing signs of distress in client and know how to access available emergency resources if a crisis situation occurs;
6. Not be a recipient of personal assistance services for the tasks s/he is being paid to perform; and
7. If the provider is an Adult Day Service, maintain all standards and requirements outlined in 473 NAC 5-002.

15-006.01A General Provider Standards: As listed on Form MILTC-9, an approved provider must agree to:

1. Follow all applicable regulations in Nebraska Administrative Code Titles 465, 471, 473, 474, and 480;
 - a. Bill only for services which are authorized and actually provided.
 - b. Submit billing documents after service is provided and within 90 days.

2. Accept payment as payment in full (payment from the Department of Health and Human Services Finance and Support plus the client's obligation) and assure that the rate negotiated or charged does not exceed the amount charged to private payers;
3. Not provide services if s/he is the legally responsible relative (for example, spouse of client or parent of minor child who is a client);
4. Not discriminate against any employee, applicant for employment, or program participant or applicant because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60;
5. Retain financial and statistical records for four years from date of service provision to support and document all claims;
6. Allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.72 – 74.24; and 42 CFR 431.107. Inspections, reviews, and audits may be conducted on site;
7. Keep current any state or local license/certification required for service provision;
8. Provide services as an independent contractor, if the provider is an individual, recognizing that s/he is not an employee of the Department or of the State;
9. Agree and assure that any false claims (including claims submitted electronically), statement, documents, or concealment of material fact may be prosecuted under applicable state or federal laws (42 CFR 455.18);
10. Respect every client's right to confidentiality and safeguard confidential information;
11. Understand and accept responsibility for the client's safety and property;
12. Not transfer this agreement to any other entity or person;
13. Operate a drug free workplace;
14. Not use any federal funds received to influence agency or congressional staff;
15. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect;
16. Allow checks as required in 471 NAC 15-006.03A1 on him/herself, family member if appropriate, or if an agency, agree to allow Department of Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place;
17. Have the knowledge, experience, and/or skills necessary to perform the task(s);
18. Report changes to appropriate Department staff (i.e., no longer able/willing to provide service, changes in client function); and
19. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate Department staff.

15-006.02 Specialized Provider Qualifications: A personal assistance service provider is considered to be "specialized" when s/he provides proof of one or more of the following:

1. Has successfully completed a basic aide training course that has been approved by the Nebraska Department of Health and Human Services;
2. Has passed the Nurse Aide Equivalency test;
3. Is a licensed R.N. or L.P.N. and presents a copy of the certificate or license to the worker; or
4. Has a total of 4,160 hours of experience (24 months at an average of 40 hours per week) as a personal assistance service provider.

A copy of the applicable certificate or license, or evidence of hourly experience—pay stubs or letter of verification from former employer(s)—must be presented to the local office provider approval staff, or their designee, who will make a copy to place in the applicant's file and then forward the document to Central Office with Form MILTC-9.

15-006.03 Provider Approval Process: The local office provider approval staff, or a designee, must initiate the approval process by completing Form MILTC-9, "Service Provider Agreement," and Form MC-84, "Personal Assistance Service Provider Checklist," with the provider applicant. Approval is not complete until Form MILTC-9 and any supporting documentation are sent to Central Office for review and approval.

Specifically, the following tasks must occur to approve a personal assistance service provider:

15-006.03A Initial Meeting: Local office provider approval staff or designee meets with the provider applicant and:

1. Completes Form MILTC-9 to determine if the applicant meets minimum qualifications and agrees to carry out all provider responsibilities. The provider approval staff or designee must explain each provider responsibility listed on Form MILTC-9;
2. Completes Form MC-84 at this meeting and throughout the approval process to assure that all required steps are completed; and
3. Gives the provider applicant a provider handbook and explains the contents of the handbook. Also gives the provider applicant copies of the completed MILTC-9 and MC-84 forms, assuming the applicant meets all requirements on both forms.

15-006.03A1 Requirements to Assure Criminal History and Protective Service Compliance by Providers: The local office provider staff or designee must not issue initial provider approval or must terminate an existing approval if the provider applicant indicates a history of conviction(s) regarding misdemeanor or felony actions which may endanger the health or safety of any client. This includes crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving

the illegal use of a controlled substance, or crimes involving moral turpitude on the part of the provider.

No provider approval will be issued or remain in effect if a registry/website report on the provider applicant as a perpetrator is shown as 'investigation in progress' or 'inconclusive' (CPS) or 'substantiated' (APS).

15-006.03A1a Individual Providers: Prior to approval at both the initial approval and renewal, the local office provider staff must complete the following:

1. Obtain a criminal history statement from the provider applicant. This statement must identify any record of any felony or misdemeanor convictions. This must include details, dates, and disposition (e.g., parole, probation, incarceration, fine, community service, etc.);
2. Perform a criminal background check of the provider prior to provider approval; and
3. Clear the name of the provider applicant against the HHS Adult Protective Services Central Registry, the HHS Child Central Register of Abuse and Neglect, the Nebraska Sex Offender Website, and the Nurse Aide Registry.

15-006.03A1b Agency Providers: If the provider is an agency, the local office provider staff or designee must:

1. Review the policy of the agency to determine that safeguards are in place to protect the well-being of clients. All agency providers must have a policy that fully states the agency's practice in assuring that safeguards are in place to protect the well-being of clients.
2. Review evidence that the agency's employees have been cleared against the HHS Adult Protective Services Central Registry, the HHS Child Central Register of Abuse and Neglect, the Nebraska Sex Offender Website, and the Nurse Aide Registry. Each agency provider must have a policy to determine how information found via these registries/website is used for its employees. This policy must assure that no staff person identified through this process poses a danger to the health and safety of any client. At the time of renewal, the provider approval staff or designee must review evidence that the agency continues to follow their established procedures in regard to these registries and newly-hired staff.

15-006.03A2 Specific Criminal History: The local office approval staff or designee must deny or terminate service provider approval when charges are pending or conviction has occurred in the following areas:

1. Child pornography;
2. Child sexual abuse;
3. Driving Under the Influence:
 - a. For providers of transportation services, a DUI charge is pending or a conviction has occurred within the past eight years.
 - b. For providers of non-transportation services, two or more DUI charges are pending, or convictions have occurred within the last five years, or two of any combination of DUI charges pending or convictions occurred within the last five years.
4. Domestic violence;
5. Shoplifting after age 19 within the last three years;
6. Felony fraud within the last ten years;
7. Misdemeanor fraud within the last five years;
8. Termination of provider status for cause from any HHS program within the last 10 years;
9. Possession of any controlled substance within the last five years;
10. Possession of a controlled substance with intent to deliver within the last five years;
11. Felony or misdemeanor assault without a weapon in the last 10 years;
12. Felony or misdemeanor assault with a weapon in the last 15 years;
13. Prostitution or solicitation of prostitution within the last five years;
14. Felony or misdemeanor robbery or burglary within the last 10 years;
15. Rape or sexual assault; or
16. Homicide.

Other pending charges or convictions are considered using the guidance of the general policy stated in 471 NAC 15-006.03A1 and weighted to similar offenses included in this list.

If criminal history and protective service compliance are met, the local staff or designee sends original copies of the MILTC-9 and any documentation that verifies training received to Central Office for final approval.

15-006.03B Central Office Provider Approval: Central Office staff will:

1. Receive Forms MILTC-9;
2. Receive and review any documentation of training or experience to verify qualifications for the specialized rate;
3. Assign a rate of pay (basic or specialized) if all documentation meets requirements;
4. Generate a unique provider identification number;
5. Send a letter of notification that the provider is now approved to the local staff person or designee and the provider;

6. Notify the local office or designee of any missing elements if all the required documentation is not received, and place the provider approval process on hold until proper documentation is received; and
7. Send the provider a supply of Forms MC-82, "Personal Assistance Service Provider Claim Form," and MC-37, "Service Provider Time Sheet," with explanation.

The Social Services Worker or designee may then authorize the provider for personal assistance services.

15-006.03B1 Adult Day Service Providers: If the provider is an adult day service, the local office staff person or designee must have the adult day service contact Central Office to complete a Medicaid Provider Agreement, designating the center's personal assistance provider. Once this is completed, the local staff person or designee must send the provider a supply of:

1. Form MC-82AD, "Adult Day Care Nursing/Aide Services Claim forms" instead of Form MC-82. This form is specifically tailored for claims by adult day care centers; and
2. Form MS-82, "Adult Day Care Assessment/Authorization". This is an assessment that the adult day care center must conduct with the client to determine the specific personal assistance tasks that must be completed for the client while at the adult day care center.

15-006.03C Denying a Provider Applicant: If the local office provider approval staff or designee or Central Office determines that the provider applicant does not comply with all the provider qualifications for the service to be provided, the staff or designee must:

1. Document the regulation(s) on which the denial is based and the reason(s) why the provider applicant does not comply with the cited regulations; and
2. Send a letter of notice to the potential provider including:
 - a. Explanation of the reasons for the Department's determination that the provider applicant does not comply with the cited regulations, or that the Department and the provider applicant have failed to agree on contracting issues;
 - b. Citation of the regulations on which the denial was based; and
 - c. Notification of the provider applicant's right to appeal the Department's decision/action (see 471 NAC 15-006.03F).

15-006.03C1 Voluntary Withdrawal: Written notice to the provider applicant is not required if s/he voluntarily withdraws from the approval process.

15-006.03D Provider Termination: The Department may terminate a provider agreement by giving at least 30 days advance written notice. If the provider violates or breaches any of the provisions of the Service Provider Agreement, then the Department may terminate the agreement immediately.

When an agreement is to be terminated by the Department, the local office provider approval staff or designee must:

1. Document the reason(s) for the termination; and
2. Provide written notice which includes:
 - a. Explanation of the reasons for the termination;
 - b. Citation of the regulations on which the termination was based; and
 - c. Notification of the provider's right to appeal the Department's decision/action.

15-006.03D1 Termination by a Provider: The provider may terminate an agreement by giving at least 30 days advance written notice. The 30-day requirement may be waived in case of emergencies such as illness, death or injury.

When terminating an agreement, a provider must:

1. Give written notice of the need for termination to the local office provider approval staff or designee; and
2. Document the effective date for termination, giving at least 30 days advance notice.

15-006.03E Client Notice of Provider Termination: The local office provider approval staff or designee must notify the Social Services Worker or designee of all clients being served by the provider of his/her termination.

The client's Social Services Worker or designee must notify the client immediately and work with the client to find a new provider (see 471 NAC 15-004.03D). If provider termination was done under emergency circumstances, the client and Social Services Worker may utilize the process described in 471 NAC 15-004.03E to find and approve an alternative provider.

15-006.03F Provider Appeals: All Medicaid providers have the right to appeal any decision/action that has a direct adverse effect on the provider (see 471 NAC 2-003). Hearings are scheduled and conducted according to the procedure in 465 NAC 2-001.02 and 6-000. Appealable actions include a determination that a provider standard is not met, disallowance of a claim, or other adverse decisions. Providers may not appeal service authorization terminations related to a client's eligibility or choice of provider.

15-006.04 Provider Agreement Renewal: The local office provider approval staff or designee must use the steps in 471 NAC 15-006.03 to re-evaluate each service provider. However, an in-person meeting is not required for renewal. Provider agreements must be renewed at least annually before the expiration of the Service Provider Agreement.

15-006.05 Provider Responsibilities: An approved provider must:

1. Adhere to all General Provider Standards in the Service Provider Agreement (see 471 NAC 15-006.01A);
2. Perform the personal assistance services described on the service plan;
3. Ensure that personal assistance services are provided in a manner that is consistent with the client's choice and desire to live independently;
4. Participate in the review of the client's service plan as described in 471 NAC 15-004.04, if and when the client requests him/her to participate;
5. Be sensitive to the client's needs;
6. Recognize changes in the client's condition as it relates to the service plan, and report them to the Social Services Worker or designee;
7. Submit billing on Form MC-82, "Personal Assistance Service Provider Claim Form," only for personal assistance services provided;
8. Accurately document services related to the service plan that are provided to and on behalf of the client on Form MC-37, "Service Provider Time Sheet," and submit with Form MC-82 for payment;
9. Disclose necessary medical information to all clients for whom services are being provided, to allow for the safety of both client and provider;
10. Not apply physical restraints to the client unless documented in the service plan;
11. Retain the following materials for four years:
 - a. Documentation that supports provision of services to each client served;
 - b. Any other documentation determined necessary by the Department to support selection and provision of services under a service plan;
 - c. Financial information related to the personal assistance services that are necessary to allow for an independent audit under Medicaid;
 - d. Documentation that supports requests for payment; and
 - e. Provider agreements with the Department.
12. Give adequate notice to the client when unable to provide scheduled services.
13. Not harm or exploit the client or client's household members, including acts of physical or verbal abuse, theft, or misuse of household belongings, personal funds, prescriptions or other medical supplies;
14. In an emergency situation, attempt to locate temporary coverage when unable to provide scheduled services;
15. If the provider is an adult day service, submit billing on Form MC-82AD; and
16. If the provider is an adult day service, complete Form MS-82 for each client being provided personal assistance services with the client, and submit to the client's Social Services Worker for review.

15-006.06 Provider Payment Process: Before authorizing a personal assistance service provider, the Social Services Worker must obtain the client's signature on IRS Form 2678, "Employer Appointment of Agent," in order to withhold taxes from the provider on behalf of the client, if appropriate.

To receive payment after personal assistance services are provided, the provider must:

1. Complete Form MC-37 which allows the provider to record the starting and ending times and a description of services provided each day;
2. Complete Form MC-82 for each client receiving personal assistance services, for the same time period as that reflected on Form MC-37;
3. Sign both forms;
4. Obtain the client's signature on Form MC-37; and
5. Submit both forms to the client's Social Services Worker or designee.

15-006.06A Billing by Adult Day Service Providers: Adult day services must complete Form MC-82AD instead of Form MC-82 to claim payment and are not required to submit time sheets specifically for personal assistance services.

15-006.06B Frequency of Billing: Providers may not bill more than one time per week but must bill at least monthly.

15-006.06C Social Services Worker Actions: After receiving both forms, the client's Social Services Worker or designee must:

1. Verify that the hours worked and services provided fall within the parameters of those authorized;
2. Sign both forms, including documentation of authorized units in the "Local Office Use Only" section of Form MC-82;
3. Copy both forms for the client's and provider's files; and
4. Send Form MC-82 to the Claims Payment Unit in the Department of Health and Human Services Finance and Support within three days of receiving it from the provider.

15-006.06D Claims Payment Actions: The Claims Payment Unit must:

1. Enter the dates and units of service into the Medicaid Management Information System (MMIS); and
2. Process the claim for payment.

15-006.06E Provider Rates: The Central Office determines rates on a statewide basis. These rates are contained in the Nebraska Medicaid Personal Assistance Service Rate Listing (see 471-000-515). The Department has the authority to adjust the rate schedule.

15-006.06E1 Adult Day Service Rate: A specific rate for adult day services providing personal assistance service is determined by Central Office.

15-006.06F Authorization for Payment:

1. The Social Services Worker or designee must prior authorize payment for personal assistance services. Authorization to provide services and to receive payment for personal assistance services is effective on the date that Form MILTC-9 is signed and dated by the Social Services Worker or designee.
2. Retroactive payment is not allowed.
EXCEPTION: Only in circumstances where emergency authorization of a provider is necessary, it is allowable to pay an alternative provider for services provided before approval and authorization is completed (see 471 NAC 15-004.03E).
3. If electronic prior authorization requests are submitted, the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) must be used. If electronic claims are submitted, the appropriate standard electronic format (ASC X12 837) must be used.

15-006.06G Provider Social Security Tax Withholding:

15-006.06G1 Affected Providers: In some situations, the Department of Health and Human Services Finance and Support withholds Social Security taxes (Federal Insurance Contribution Act, FICA) from provider payments. The employee's share of Social Security tax is withheld from provider payments only when in-home service is provided by an individual not affiliated with an agency. The Department of Health and Human Services Finance and Support, upon receiving a signed IRS Form 2678, "Employer Appointment of Agent," acts on behalf of clients who receive in-home services to withhold mandatory FICA taxes from individual providers and pays the client's matching tax share to the Internal Revenue Service (IRS).

15-006.06G2 Earnings Taxed for Social Security: Affected providers are subject to Social Security tax payment for each calendar year in which they are paid a federally determined amount or more for services provided to one client. (For example, for calendar year 2002 the base amount was \$1,300 paid for FICA-covered services per client.) The Department of Health and Human Services Finance and Support must withhold this tax from all payments to affected providers. If a provider's earnings do not reach this annual amount for FICA services per client, the amount withheld for that year is refunded to the provider.

15-006.06G3 Social Security Tax Rates: The Department of Health and Human Services Finance and Support remits to the IRS an amount equal to the current Social Security tax rate for specified "in-home" services. Half of this amount is withheld from the provider as the employee's share; the other half is provided by the Department of Health and Human Services Finance and Support on behalf of the client employer.